Best wishes for
a happy and prosperous New Year from the Editorial Team

NHS Lothian

LOTHIAN PRESCRIBING BULLETIN

Supporting prescribing excellence - informing colleagues in primary and secondary care

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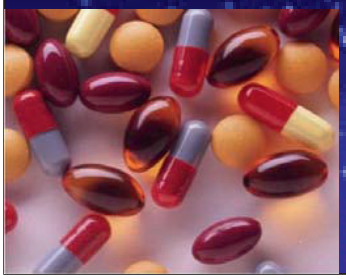


In this issue …

Prescribing in women of childbearing age with diabetes

Scotland has an obesity epidemic and as a consequence there is a rising prevalence of type 2 diabetes in the younger population. The development of type 2 diabetes at a young age is associated with a more rapid development of macrovascular complications and therefore aggressive cardiovascular risk reduction is mandatory. Increasing numbers of women with type 2 diabetes of childbearing age are being treated with drugs previously used in later life.

SIGN 116[1] recommends treating patients with diabetes and associated hypertension with either angiotensin-converting enzyme (ACE) inhibitors or angiotensin receptor blocking agents (ARBs), and also recommends that all patients over the age of 40 should be treated with statin therapy irrespective of baseline lipid profile.

The SIGN guidelines also emphasise the importance of pre-pregnancy planning for patients with diabetes to avoid the significant risks associated with pregnancies complicated by diabetes. Whilst some of this risk can be attributed to hyperglycaemia and/or complications of diabetes per se, another concern is the use of drugs that have adverse effects on foetal development. Pre-pregnancy care includes the avoidance of unplanned pregnancy with appropriate contraception, commencement of high dose (5mg) folic acid prior to conception, followed by a multidisciplinary approach to optimise glycaemic control and monitor for diabetic and obstetric complications.

Since ACE inhibitors, ARBs and statins have all been associated with congenital anomalies (including renal dysplasia, oligohydramnios and incomplete ossification of the skull) both SIGN 116[1] and the BNF[2] recommend avoiding these drugs during pregnancy. These therapies should therefore be discontinued before conception, and at least as soon as pregnancy is confirmed. For the management of hypertension, a suitable alternative agent such as labetalol or methydopa should be considered. Metformin, used first line in patients with type 2 diabetes, is considered safe in pregnancy and should be continued. Patients planning a pregnancy or found to be pregnant should be referred urgently to a specialist diabetes clinic for further management of pregnancy in diabetes.

Helpful advice for patients:

- **Ensure patients are counselled on the importance of avoiding unplanned pregnancies**
- **Encourage women with diabetes to attend for pre-pregnancy planning**
- **Some medications, including statins, ACE inhibitors and ARBs are not safe during pregnancy and should be stopped when trying for a baby or as soon as pregnancy is confirmed**
- **Metformin is considered safe in pregnancy and should be continued.**

References

1. Management of Diabetes. SIGN Guideline116. Scottish Intercollegiate Guidelines Network. March 2010. www.sign.ac.uk/guidelines/fulltext/116/index.html Accessed 16/12/11
2. British National Formulary. Number 62. September 2011 http://bnf.org/bnf/index.htm Accessed 16/12/11

Thanks to Dr Anna Dover and Dr Liesbeth Van Look, Department of Diabetes, St John's Hospital, for contributing this article.

Consultation techniques to reduce antibiotic use

There is lots of evidence to indicate that we should be using less antibiotics in primary and secondary care.[1] The key area where we are most likely to do this safely and improve patient care is in the management of self-limiting respiratory tract infections. As well as tackling the problems of antibiotic resistance and healthcare associated infection, reducing antibiotic prescriptions has been shown to reduce demand on GP time by de-medicalising self-limiting conditions and encouraging self-care.[2]

CONSULTATION TECHNIQUES

General Approach: The consultation techniques recommended by NICE 69[3] as strategies for reducing antibiotic use may appear to be simplistic, but this is where the evidence lies. These approaches endorse the skill and expertise of traditional general practice.

Expectation: The first consultation strategy is to discuss early on whether the patient expects to leave the room with a prescription for an antibiotic. This is a reminder of the RCGP consultation model technique of *'identifying the patient's need*'. '*Was there anything that you were hoping for today?*' is a phrase used in consultation technique training, yet its value and use can get lost by more established GPs. Roger Neighbour's '*summarising*' is another consultation technique that could equally be used to good effect here.

Safety Netting: Clear and documented safety netting is vital to ensure a robust approach to the self-limiting respiratory tract infection consultation.

Examination: There is clear evidence that patients value detailed examination over and above receiving a prescription for antibiotics.[4] It is well worth spending an additional couple of minutes doing a thorough examination. This is especially important when using some of the diagnostic aids (e.g. Centor Criteria) to identify those patients that really should be considered for immediate antibiotic treatment.

Delayed Prescription: If the patient remains unconvinced of the recommendation for no antibiotics, the use of a delayed antibiotic prescription has been shown to reduce overall consumption of antibiotics. It is important to discuss this strategy within the practice as the logistics of the practicalities will differ between practices.[3] Options include giving the patient the antibiotic prescription and advising they get it dispensed if no better after the agreed time frame. Another option is to leave the prescription at reception for the patient to collect after the agreed time duration. If not collected remember to log this on the clinical record. There is a READ code for 'deferred antibiotics'.

Explanation: Within the explanation part of the consultation it may be helpful to discuss resistance. We now have good quality primary care prescribing evidence that shows antibiotic use results in the sustained presence of resistant bacteria for the patient.[1] This personalises the bacterial resistance argument and can be a particularly powerful piece of evidence when negotiating with patients whether to avoid the use of antibiotics. There is the paradox that the virus argument can increase expectation for an antibiotic. This strategy does work for some clinicians, but for self-limiting respiratory tract infections often the causal organism is irrelevant, and the patient still has the capacity for recovery whether bacteria or virus.

Advice: NICE 69[3] provides advice on illness duration and symptom management. Dose advice on analgesia is particularly important as parents tend to underestimate how much their child has been given.[5] NICE 47[6] recommends that ibuprofen and paracetamol should not be used in combination as an antipyretic, however this combination remains acceptable for pain relief. Patient advice leaflets are available from Clinical Knowledge Summaries (CKS).

Consultation Aids: There are various consultation aids which can further inform discussion about the poor benefit of antibiotics for self-limiting respiratory tract infections and potential for harm. Although it has to be purchased from the RCGP, *'When Should I Worry – your guide to coughs, colds, earache and sore throats'* is a tool that can be used to communicate the NNT and NNH with patients and parents.

The third and final article in this series on reducing antibiotic use in self-limiting respiratory tract infection will focus on when to consider targeted antibiotic use.

References

1. LPB No.52. November 2011. www.ljf.scot.nhs.uk Accessed 16/12/11
2. BMJ 1997;*315*:350-2. www.bmj.com/content/315/7104/350 Accessed 16/12/11
3. Clinical Guideline CG69. NHS NICE. July 2008. www.nice.org.uk/CG69 Accessed 16/12/11
4. Br J Gen Pract 2007;*57(540)*:561-8. www.ncbi.nlm.nih.gov/pmc/articles/PMC2099639/ Accessed 16/12/11
5. BMJ 2001; 322:336-42 www.bmj.com/content/322/7282/336.full Accessed 16/12/11
6. Clinical Guideline CG47. NHS NICE. May 2007. www.nice.org.uk/CG47 Accessed 16/12/11

Bits and pieces – *but still important*

Detailed below are some 'snippets' you might have missed over the last few months and some important reminders. (*For those reading paper copies – have a look at this online and you can access the weblinks.)*

UTI prophylaxis

Are you in the habit of prescribing antibiotic prophylaxis for recurrent urinary tract infections? LJF advice states that *"Prophylaxis is not generally recommended for recurrent UTI or asymptomatic bacteruria."*

Missed pill advice

Advice for missed combined oral contraceptive (COC) pills has been simplified; the same advice is relevant for all doses of COC. Full information is available in the BNF section 7.3.1 or on the Faculty of Sexual and Reproductive Healthcare Clinical Effectiveness Unit (FSRH) website.

ESPRIT guidance on generic transplantation medicines

Previous issues of the LPB have highlighted the importance of prescribing immunosuppressants by brand name (LPB Issues No 43 and No 35.) There are now several generic immunosuppressants on the market.

These immunosuppressants should only be initiated within the specialist hospital setting. **Prescriptions and correspondence should specify the brand the patient is stabilised on**. ESPRIT (Efficacy and Safety of PRescribing In Transplantation) issued a consensus statement in August 2011.

Paracetamol dosing in children

In June 2011 the MHRA issued updated paracetamol dosing for children, to ensure that children get the most effective and safe amount. This updated information should now be included in the packaging for paracetamol products. The LJF is in the process of being updated.

Ciprofloxacin for meningitis contacts

The Health Protection Agency issued updated guidance for the management of meningococcal disease in the UK, and NHS Lothian has updated the '*Meningococcal Policy*', which is on the intranet at http://intranet.lothian.scot.nhs.uk/NHSLothian/Healthcare/A-Z/InfectionControl/icm/Documents/CP0019.pdf From the perspective of prescribing the main change is that ciprofloxacin is the chemoprophylaxis agent of choice, for adults and children, rather than rifampicin. Ciprofloxacin's advantages are it is given as a single dose, does not interact with oral contraceptives and is more readily available in community pharmacies.

Fostair® guidance

Prescribing guidance for Fostair® (beclometasone plus formoterol) has been developed for general practice. The guidance aims to provide additional information for prescribers when the decision has been made to step up treatment from an inhaled corticosteroid to a combination inhaler. Fostair® is the LJF first choice combination inhaler for asthma in adults. The guidance is available on the LJF website, in the Education and Training section.

Oilatum® for children

Oilatum® is the first choice emollient bath additive in both the Adult and Child LJF. Analysis of PRISMS data over the last year has however highlighted the growing use of Oilatum® Junior bath additive. Data from April to June 2011 indicates that Oilatum® Junior bath additive is frequently prescribed by GPs (1356 items), community pharmacists (237 items, via Minor Ailment Service) and nurses (161 items).

Oilatum® Junior bath additive contains exactly the same active ingredients as the standard Oilatum® preparation, but as it is produced for the over-the-counter market it is significantly more expensive.

The cost of Oilatum® Emollient bath additive is £2.75 for the 250-mL pack, whilst the cost of Oilatum® Junior bath additive is £3.25 for the 250-mL pack. By prescribing only Oilatum® Emollient bath additive, NHS Lothian could save in the region of £10,000 a year.

If non-drug treatment does not help insomnia prescribe *Zzz zopiclone*

Practical measures that promote sleep are the first-line treatment for insomnia. Such measures include creating a suitable sleeping environment and the avoidance of alcohol, large meals, caffeine at night and day-time napping. Cognitive and behavioural therapies are also options prior to pharmacotherapy.[1]

The Lothian Joint Formulary (LJF) recommends zopiclone as second line to these practical measures. Zopiclone has replaced temazepam as the hypnotic of choice for short term use to treat insomnia in new patients. It has been shown to be equally as effective as, and more cost effective than, temazepam for treating insomnia. It does not require the special storage required for temazepam, a schedule 3 controlled drug.

Switching between hypnotics is not recommended unless due to adverse effects specifically related to one hypnotic. Patients currently treated with temazepam should continue treatment with this medication. If patients do not respond to one hypnotic medication they should not be switched to another hypnotic.

Key messages:

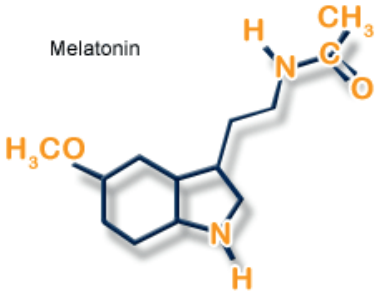
- **The hypnotic of choice in the LJF is zopiclone; temazepam is no longer recommended in Lothian for insomnia**
- **Zopiclone may be prescribed for insomnia after consideration of non-pharmacological measures**
- **Zopiclone should be prescribed short term only, for the management of severe insomnia interfering with normal daily life**
- **Hypnotics should not be on a repeat prescription system and existing patients receiving a hypnotic should be reviewed and offered the chance to stop or reduce (see BNF protocol on benzodiazepine withdrawal[2])**

Reference

1. Zaleplon, zolpidem and zopiclone for the management of insomnia. NHS National Institute for Health and Clinical Excellence (NICE) Technology Appraisal Guidance 77. April 2004. www.nice.org.uk/guidance/TA77 Accessed 19/12/11
2. Dependence and withdrawal of benzodiazepines. British National Formulary. http://bnf.org

Wake up to the melatonin issue

Melatonin is prescribed under a shared care protocol (SCP) for the treatment of sleep-wake cycle disorders in children and the average monthly prescribing cost is in the region of £20,000 per month. Recent analysis of prescribing data and the results of a general practice audit have indicated that there is a vast array of melatonin preparations (capsules, tablets and liquid in different strengths from 1mg to 10mg) being prescribed and dispensed across NHS Lothian. There are currently only two Lothian recommended products for this indication: **Bio-melatonin®** 3mg tablets (unlicensed) and **Circadin®** 2mg modified release tablets (off-label) and these should be requested, prescribed and dispensed by brand to ensure that the correct intended product is supplied to the patient.



Pharmacy supply issues:

Circadin® 2mg modified release tablets are available via the usual pharmaceutical wholesaler. Cost £10.77/21 (BNF, Sep 2011).

Bio-melatonin® 3mg tablets are an unlicensed medicine. Ordering directly from Pharma Nord (UK) is the least expensive and recommended route, telephone 01670 519989, fax 01670 534 903.

Supplement: Recent SMC and Lothian Formulary Committee Recommendations

This supplement is available at LJF website www.ljf.scot.nhs.uk in 'Prescribing Bulletins'.

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View the Lothian Joint Formulary at www.ljf.scot.nhs.uk